safety, and the efficiency, of resorting to this drainage by the vagina in every case of ovariotomy, both as a preventive and curative agent against septicæmia, which, I am sure, is the great danger in this formidable operation."

Since May, 1872, Dr. Sims has performed four ovariotomies with the drainage plan.

Absorption of the Humerus after Fracture.—From the *Boston Medical and Surgical Journal* (Oct. 10, 1872) we glean the following notes of a case which is stated on excellent authority to be "without parallel in the records of surgery:"—

In 1819, Mr. C. B., at the age of 18, fractured his right humerus near the middle. Subsequently, and before he had recovered entirely, he broke his arm at the same point, a second time, while holding a plough in the field. A short time afterward he slipped on the floor and fractured the bone a third time. The last accident was not more than two months from the occurrence of the first. After this final fracture, there was never any tendency to a union of the broken bone, but the humerus began slowly and painlessly to disappear, small fragments of it breaking off, without accompanying inflammation of the soft parts, or any fistulous or suppurating sore, or orifice. The skin of the arm was never broken, and no piece of bone or part of the humerus was ever taken away, or came out unassisted. For four years, Mr. B. did no work, but the process of absorption covered a period of twelve years, at the end of which time the limb had attained a condition in which it permanently remained until the day of his death, at the age of 70 years. This occurred at the Boston Lunatic Hospital, on February 11th, 1871, and was caused by double pneumonia. He had been an inmate of this Institution, at intervals, for four years and three months, but, except in mental condition, was, as he had always been, in excellent general health, with no local affection of his osseous system, except in the arm already alluded to, and capable of a very considerable amount of manual labour, which he willingly and readily performed.

Dr. C. B. Porter, Demonstrator of Anatomy in the Medical Department of Harvard University, gives the following description of the specimen:—

"All traces of the humerus are obliterated, except its two extremities. The remains of the lower extremity consist of a small, somewhat irregular, pyramidal piece of bone and cartilage, an inch and a half long, three-quarters of an inch wide at its base, its apex pointing upward and somewhat outward. This articulates in a very imperfect way with the radius and ulna, both of whose upper extremities are modified by absorption, and their shafts fused together for their upper third into one slender bone, tapering off in a small and imperfect olecranon. This anchylosis at the upper part of the forearm reduces the rotation of the radius on the ulna at the wrist to a very slight motion. The remains of the upper extremity of the humerus consist of a thin, auricular-shaped plate of bone, two inches long and one inch wide, in close relation with the glenoid cavity, but presenting no real articular surface. On the outer and upper edge of this piece are inserted the tendons of the supra- and infra-spinatus and teres minor, defining this as the greater tuberosity. Just below this is another bony fragment, an inch long, half an inch wide, slightly concave, into the anterior border of which is inserted the tendon of the pectöralis major. Into the inner and upper border is inserted the tendon of the teres major. The latissimus dorsi, which normally should be inserted with that of the teres major, is inserted, however, into the lower border of the teres major, midway between its origin and insertion. A strong, fibrous band connects it with this last-mentioned fragment of bone. A third piece, a small nodule, four lines long by two lines wide, is attached to this plate on its upper and internal aspect by a tendinous band; the tendon of the subscapularis muscle is inserted into this nodule, characterizing it thereby as the lesser tuberosity of the humerus. The articular surface of the glenoid cavity is obliterated; the bone itself only slightly if at all modified. The intervening space between the upper and lower fragments of the humerus is occupied by a fibro-muscular mass, and about half the normal length of the humerus, judging from the size of the scapula and the length of the forearm. This is made up, principally, of the brachialis anticus and the triceps, united closely to each other. The biceps, lying anterior to this, arises and is inserted normally. The deltoid and coraco-brachialis arise normally, and are inserted, the former into the outer, the latter into the anterior surface of the mass described. The scapular head of the triceps arises normally; the other two heads are blended in this central mass, which gives origin, also, to the brachialis anticus in front. These two muscles, as they approach the elbow-joint, surround the remains of the lower end of the humerus and pass onward to become blended with the origins of the extensor and flexor muscles of the forearm, with no definite point of insertion. The supinator longus and the flexor carpi radialis longior take origin from the fibro-muscular mass. The humeral origin of the remaining muscles of the forearm is blended with the insertion of the muscles of the arm. All the bony prominences at the elbow-joint are so modified and absorbed as to bear no resemblance to the properly-developed bones. The muscles thus described, although somewhat fatty and atrophied, still present a very fair amount of development, and are well defined and readily distinguished and separated from each other.

"The arteries, veins, and nerves are not preserved in connection with the muscles, but at the time of the dissection a careful examination revealed no traces of a departure in them from an apparently natural and healthy condition."

The serviceableness of this limb has been alluded to. Mr. W. E. Mosely, Resident House Pupil at the Lunatic Hospital, states that Mr. B. could hoe, rake, shovel, sweep, cut wood, carry a large pail of water, hold a knife at the grindstone, and write a good hand. (He used to write letters for other patients.) He took care of his own room and made his own bed. By twisting the upper part of his arm, he could use his fingers well enough to tie his neck handkerchief. He could not flex the forearm upon the upper arm at will, nor could he extend the forearm when flexed, unless in a position in which the weight of the arm would make it drop. The muscular power of the arm was very considerable.

Hydrocele of the Seminal Vesicle.—Prof. N. R. Smith, of Baltimore, records (*Lancet*, Oct. 19) the following interesting case of this :—

Prof. S. was called in consultation to a gentleman represented to have retention of urine. "I found," Prof. S. states, "a large pyriform tumour occupying the cavity of the pelvis, and also that of the abdomen, higher than the umbilicus. There was no gaseous resonance over any part of it, but when percussed it sounded and vibrated like a fluid in a tensely distended sac. The patient was passing, every hour, half an ounce of urine perfectly normal in character. The attending physician assured me that he had repeatedly introduced the catheter into the bladder and had not drawn more than an ounce of urine; not in the least reducing the volume of the tumour. Still I had not the slightest doubt that I was dealing with a distended bladder. . . .

"I was greatly surprised, then, when on introducing a long catheter fairly into the bladder there flowed only an ounce of perfectly normal urine. On placing my hand on the tumour, I found it not in the least reduced in size, and, as I moved the catheter, I distinctly felt the instrument gliding about in close contact with the walls of the belly, being pressed forward by the pyriform tumour.

"Here, for a moment, we were completely at fault—the tumour was not the distended bladder, but was manifestly a cyst, containing a fluid. It was posterior to the bladder, and displaced that organ forward. After another careful exploration externally, I introduced my finger into the rectum, and found the prostate normal; but, on carrying the finger deeply and to the left of it, I at once encountered an elastic tumour communicating the sensation of a sac tensely distended with fluid. On palpating with the other hand on the abdomen, the vibratory motion of a fluid was manifest.

"The matter was now clear. We had a hydrocele of the left seminal vesicle. We at once resolved on tapping through the rectum. This I effected with an ordinary straight trocar. On withdrawing the stylet, the fluid issued with force, and, in a few minutes, we drew off ten pints of a brown serous fluid, bearing no resemblance to urine.